Your Anthem Benefits

Anthem

STATE OF INDIANA: TRADITIONAL PLAN II
Blue Access℠ (PPO)
Summary of Benefits for 2006

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Deductible (Single/Family) *(Applies only to percent (%) copayments)* *Deductibles are co-mingled network and non-network*	$ 0 single Network/Non-network $ 0 family Network/Non-network
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled network and non-network Rx copay(s) do not accrue to out of pocket	$2,000 per enrollee $4,000 per family The out of pocket maximum limit accrues on a calendar year basis. After the out of pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.
Professional Office Services • Including allergy – testing and treatment – serum and injections	$20 Network/ 40% Non-network Per Visit
Preventative Care Services	$20 Office Visit Copay Network/40% Non-network Services include: immunizations for eligible dependents, annual physicals for for employees and their eligible covered dependents, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.
Maternity Services	$500 Network/ 40% Non-Network
Inpatient Facility Services	$500 Network/40% Non-Network
Outpatient Facility Services	$250 Network/ 40% Non-network
Professional Inpatient/Outpatient Services	Covered In Full Network/40% Non-Network
Emergency and Urgent Care: • Emergency Care in ER Room • Urgent Care Facility	 $75 Network or Non-Network $35 Network or Non-Network
Ambulance	$50 Copay Network or Non-Network
Radiation/Inhalation Therapy	$20 Office Visit Copay Network/ 40% Non-network
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	$20 Office Visit Copay Network/ 40% Non-network
Mammogram	$20 Office Visit Copay Network/ 40% Non-network Includes 1 per person, per calendar year. Additional mammography services and ultrasounds are covered as determined medically necessary by your physician.
Routine Prostate Antigen Tests (PSA)	$20 Office Visit Copay Network/ 40% Non-network Includes 1 per person, per calendar year
Colorectal Cancer Exam/Laboratory Testing	$20 Office Visit Copay Network/ 40% Non-network
Diabetes Self Management Training	$20 Office Visit Copay Network/40% Non-network
Diagnostic Services i.e. lab, x-ray, MRI	Covered In Full Network/40% Non-network

Temporomandibular Joint (TMJ) Services	Outpatient Facility $250 Copay Network / 40% Non-network Provider Individual: $20 Office Visit Copay/ Network/40% Non-network TMJ Surgery: Covered In Full Network/40% Non-network TMJ Services: $2,500 lifetime maximum for all services (network/non-network)
Hospice	20% Network/20% Non-network
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	$20 Copay per day Network/ 40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee
Home IV Therapy	$20 Copay per day Network/ 40% Non-network
Employee Assistance Program	Provides consultation and referral services for personal concerns for employees and their household members.
Managed Mental Health including Substance Abuse Covered Same As Any Other Condition	Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed. $500 In Patient Copay Network/ 40% Non-network $20 Office Visit Copay Network/ 40% Non-network *THESE SERVICES MUST BE CERTIFIED BY CONTRACTOR TO RECEIVE BENEFITS.
Lifetime Maximum Includes Human Organ and Tissue Transplants (HOTT)	$2 million Network and Non-network combined
Human Organ and Tissue Transplants (HOTT) Specialty Network	$2,000 Network / 40% Non- network See contract for other maximums and exclusions

Prescription Drug Options:
Network Tier structure equals 1/2/3 (and 4, if applicable)
Including Birth Control

Network Retail Pharmacies:
100% of allowable cost after copayment up to a maximum of 34-days supply of medication or 100 units

Anthem Rx Direct Mail Service:
100% of allowable cost after copayment up to a 90 day supply

	Network	Non-network
Tier 1	$10	40%
Tier 2	$20	40%
Tier 3 & 4	40% (Minimum $40, Maximum $100)	40%
Tier 1	$20	Not Covered
Tier 2	$40	
Tier 3 & 4	40% (Minimum $80, Maximum $150)	Not Covered

The network penalty will be waived if there is no network pharmacy within 12 miles of the participant's home.

The prescription drug copays do not apply to the medical out-of-pocket.

	Now Called:	Previously known as:
Tier 1	Preferred Prescription Drugs	Generic
Tier 2	Preferred Prescription Drugs	Formulary Brand
Tier 3	Non-Preferred Prescription Drugs	Non-Formulary Brand
Tier 4	Prescription Drugs	Mostly injectable drugs

See Benefit Booklet for exclusions.

Notes:

- Dependent age: to end of the calendar year after the child's 19th birthday; or to the end of the calendar year after the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No deductible carry over credit

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.